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Chairman Thomas, Congressman Stark, distinguished Subcommittee members, thank you for inviting us to discuss the need to make further adjustments to the Balanced Budget Act of 1997 (BBA). Congress and the Administration worked together to make difficult decisions in enacting this historic law. The BBA helped to eliminate the deficit, created the State Children's Health Insurance Program, and reduced and restructured Medicare and Medicaid payments to health care providers. Many of the provider payment changes were justified and have contributed to improved efficiency and the unprecedented fiscal health of the Medicare Trust Fund.

However, information gathered over the last three years suggests that some of the policies may have the potential to affect the quality of and access to health care services. To address this, the President worked with Congress to increase home health care payments in 1998. We worked together again last year in the Balanced Budget Refinement Act (BBRA) to make several necessary adjustments for several types of providers. And we have taken several administrative actions to smooth the transition to new policies and help health care providers adjust.

It appears, however, that problems persist. We have all heard reports from health care providers of financial difficulties -- in part related to BBA changes. We are concerned about the potential for reduced beneficiary access to quality care. We believe it is warranted to make further prudent adjustments to ensure that beneficiaries continue to have access to quality care. And we want to work with this Committee, as we have done in the past, on legislation to make needed adjustments.

The President=s Mid-session Review proposal includes numerous adjustments that would increase payments by $21 billion over 5 years ($40 billion over 10 years) to hospitals, rural providers, teaching facilities, nursing homes, home health agencies, managed care plans, and other providers.

The President=s proposal includes $9 billion over five years ($19 billion over 10 years) to delay further BBA payment reductions, many of which are scheduled to occur on October 1, and includes $11 billion over five years ($21 billion over 10 years) in unspecified funds for use in developing additional adjustments.

PRESIDENT=S MIDSESSION BUDGET PROPOSAL Dollars in Billions

HOSPITALS 5 Years 10 Years

- Full inpatient hospital market basket for '01: $4 $8
- Indirect Medical Education at 6.5 percent for '01: $0.2 $0.2
- Repeal Medicare DSH reduction for '01: $0.2 $0.2

- Freeze in Medicaid DSH allotments for '01: $0.3 $0.3
- Rural initiative: $0.5 $1.0
- Adjusting Puerto Rico hospital payments to 75/25 blend: [1] $0.05 $0.1

Total: $5 $10

HOME HEALTH

- Delay 15 percent cut in '02: $1 $1
- Full market basket update for '01: $1 $2

Total: $2 $3

NURSING HOMES

- Full market basket update for '01: $0.6 $1
- Delay therapy cap changes for an additional year: $1 $1

Total: $1.6 $2

MEDICARE+CHOICE

- Indirect effect of specified policies: **$1 $3**

OTHER

- ESRD composite rate update of 2.4% for '01: **$0.2 $0.5**

TOTAL SPECIFIED POLICY COSTS: $9 $19

UNSPECIFIED PROVIDER RESTORATION POOL: $11 $21

TOTAL FUNDING: $21 $40

NOTE: Numbers may not add due to rounding. Ricky Ray and diabetes increases would be funded out of the unspecified pool.

The BBA=s fiscal discipline and our success in fighting fraud, waste, and abuse have greatly improved the status of the Medicare Trust Fund, which is now projected to remain solvent until 2025, 26 years beyond where it was just 8 years ago. The prospective payment systems mandated by the BBA are particularly important because they create incentives to provide care efficiently.

However, these new payment systems mark a substantial departure from cost- and charge-based reimbursement, and the transition can be challenging for providers.

The improved status of the Medicare Trust Fund and the growing budget surplus make it possible to pay for new BBA adjustments to help providers adjust to these changes while still achieving the President=s goal of extending the Trust Fund to at least 2030 and adding an affordable, voluntary prescription drug benefit that is available to all beneficiaries. In addition to the specific fee-for-service provider payment adjustments listed above, the President=s plan would provide an estimated $25 billion over five years to Medicare+Choice plans specifically for drug coverage.

MEDICARE+CHOICE

Medicare+Choice (M+C) plans are finding it difficult to adjust to the BBA changes while maintaining the extra services they have provided to beneficiaries in the past. This is especially true for prescription

drug coverage that is not available in the Medicare fee-for-service program and which many M+C plans offer, but for which they do not receive specific payment from Medicare. Many M+C plans were able to offer drug coverage and other extras because of excessive payments that were made to them before the BBA.

However, since the BBA was enacted, costs of the extra benefits provided under many M+C plans -- particularly prescription drugs that are not offered in the Medicare fee-for-service program -- have increased much faster than spending for services in the Medicare fee-for-service program. Our success in holding down fee-for-service costs is due in part to BBA provisions and our fraud, waste, and abuse efforts, as well as other factors. Because payments to M+C plans do not account for the costs of services which are not covered in the Medicare fee-for-service program, plans have significantly reduced the scope of their prescription drug coverage. For example, in the last two years, the proportion of plans that limit drug coverage to $500 or less has increased by 50 percent. In 2000, about 75 percent of plans limit drug coverage to $1,000 or less.

Lack of payment to support drug coverage that is not available in fee-for-service Medicare is a primary reason that some M+C plans are again announcing that they will leave or reduce participation in the program, particularly those with smaller market shares and strong competition. Difficulty in maintaining provider networks is also a factor, as demonstrated by a recent Deloitte & Touche report showing that half of the nation=s largest hospitals canceled an HMO contract in the past year. Because some M+C plans believe that they cannot be competitive if they charge a higher premium or reduce benefits, they have simply decided to withdraw from the program. We have no control over their actions. We do believe, however, that even with premiums, M+C plans still represent a valuable option for beneficiaries -- particularly as an alternative to Medigap.

For 2001, about 85 percent of current M+C enrollees will be able to continue with their current HMO. However, 65 M+C organizations have announced they will leave the program and 53 will reduce their service areas, affecting a total of 934,000 Medicare enrollees. More than 775,000 should have the opportunity to enroll in another M+C plan, but about 159,000 will be left with no other managed care option and few, if any, options for affordable drug coverage.

Nonetheless, payments to M+C plans continue to exceed what taxpayers would spend for enrollees if they had remained in the fee-for-service program. The General Accounting Office (GAO), in testimony before Congress last week, affirmed that this is still the case despite BBA payment changes and that AMedicare managed care, although originally expected to achieve program savings, continues instead to add to program cost.@

The best way to ensure that the M+C program is a strong part of Medicare and an important option for beneficiaries is to ensure that all beneficiaries have access to affordable drug coverage and to pay plans directly for providing it. The President=s proposal to create a voluntary, affordable Medicare prescription drug benefit for all beneficiaries would do just that. Under the President=s proposal, M+C plans would be paid through a competitive, market-based process in relation to their own costs, rather than through Congressionally mandated administrative prices that have resulted in wide variation in rates and beneficiary access to plans across the country.

Also, plans would be paid $2 billion directly beginning in January and $25 billion over the next five

years to provide the prescription drug coverage that most beneficiaries want from managed care. This amount substantially exceeds the $15 billion over five years that representatives of the American Association of Health Plans have said, in testimony before Congress, they need to continue participating in the M+C program. Beginning in 2002, beneficiaries in fee-for-service Medicare would also be able to choose this benefit, regardless of whether they live in areas where managed care plans have chosen to operate. And beneficiaries in M+C plans all across the country would be assured of drug coverage, rather than just those in areas where non-targeted assistance for M+C plans would raise payment enough to support a drug benefit.

In addition, under the President=s Mid-Session Review proposal, M+C plans would receive an additional $1 billion over five years through increases to the payment rates which are based on the fee-for-service Medicare system. We also announced on June 19 that we will work with the Medicare Payment Advisory Commission (MedPAC), plans, beneficiary groups and others to develop a slower phase-in of the current schedule for risk adjustment, administratively addressing the concerns about the current schedule, while maintaining our commitment to using comprehensive outpatient data beginning in 2004.

Meanwhile, to make sure that Medicare is a fair business partner, we have been streamlining the requirements for M+C plans while making sure that beneficiaries who choose managed care receive the benefits, protections, and information they need and deserve. We have modified many requirements in our contracts and operations to be more consistent with private and other public purchasers, and we are implementing additional initiatives to further streamline administrative procedures and lead to more efficient and consistent oversight. Specifically, we are:

- Increasing flexibility in establishing a provider network, which will allow health plans greater opportunity to serve rural areas;
- Improving freedom of choice by allowing plans to offer beneficiaries a point of service option that broadens access to health care services from both in-network and out-of-network providers; and
- Easing compliance plan reporting by eliminating the self-reporting requirement.

Medicare beneficiaries should know that, regardless of the decisions made by private HMOs, they are still covered by a strong Medicare program. Their HMO is required to cover them until December 31, 2000. We are continuing to take strong steps to ensure that, no matter what decisions plans make about their participation in the program, Medicare beneficiaries affected by these changes have options. We are ensuring that beneficiaries who are being forced to change their health care coverage are guaranteed access to certain Medigap plans, regardless of any preexisting conditions, as the law requires. And, in order to make the transition easier for these beneficiaries and to help them make the right decisions about their health care coverage, we are providing them with clear information on their new options and requiring plans leaving the program to do the same.

HOSPITALS

Most experts agree that hospitals= financial status has worsened recently, as a result of several factors. In large part, this results from private payment reductions. MedPAC has found that about three-quarters of the decline in total hospital margins between 1997 and 1998 is due to lower private payments. While Medicare hospital inpatient margins remain relatively healthy, more hospitals had negative margins in 1998 than 1996.

Rural hospital inpatient margins dropped by nearly twice as much as urban hospital margins did between

1997 and 1998. Rural hospitals face special challenges B they tend to be smaller and often cannot attract or keep health care professionals. They also are more dependent on Medicare patients and therefore disproportionately affected by Medicare payment reductions. The BBRA invested about $1 billion over 5 years to address many of these problems. However, additional increases appear to be warranted to help the long term viability of rural hospitals.

Hospitals that serve large numbers of uninsured people also are strained by the increasing number of uninsured. Some uninsured use hospital emergency rooms for primary care while others delay care until problems become more severe and costly. While the number of uninsured has been rising, Federal payments to disproportionate share hospitals (DSH) were reduced by the BBA. This coincided with reductions in payments from private payers which traditionally had helped fund uncompensated care. And academic health centers, which play critical roles in making medical advances, caring for some of the most complex cases, and providing service to underserved populations, also have experienced a significant decline in total hospital margins.

To mitigate these funding problems, allow for more time to assess the full impact of the BBA and BBRA, and to preserve beneficiaries= continued access to quality care, the President=s plan would:

- Replace the BBA inpatient hospital update for inflation, the Amarket basket@ (MB) minus 1.1 percentage points with a full MB update for FY 2001;
- Eliminate the BBRA indirect medical education payment reduction for FY 2001, maintaining the additional payments for IME at 6.5 percent;
- Eliminate BBRA DSH reduction of 3 percent for FY 2001;
- Replace the BBA=s Medicaid DSH reductions for 2001 with a one-year freeze, so that the Federal share DSH limits for FY 2000 would also apply in 2001.
- Reserve about $1 billion over 10 years for rural provider policies. This will include policies to improve the sustainability of rural hospitals, similar to those in the bipartisan AHealth Care Access and Rural Equality Act of 2000@, introduced by Sens. Conrad, Daschle and Reps. Foley, Berry, McIntrye, Pomeroy, Stenholm, Tanner and others. We also will consider improving equity for rural hospitals in the Medicare DSH formula.
- Provide fairer payments for inpatient services in Puerto Rico by basing the payments more on the rates that apply everywhere else in the nation.

The Mid-Session Review plan also modifies the President=s budget savings policies by dropping the fiscal 2003 through 2007 policies to reduce hospital market basket update and capital payment reductions and to further reduce hospital bad debt reimbursement. These hospital policies would have saved more than $25 billion over 10 years (before interactions).

Meanwhile, we have taken steps to help hospitals adjust to BBA and BBRA changes. Most recently, we delayed implementation of the outpatient prospective payment system to give both us and hospitals more time to prepare. We are distressed about postponing the benefits of this new system for beneficiaries, but the delay is necessary to be fully prepared for this substantial change. We also are requesting that hospitals not collect deductibles or coinsurance from Medicare beneficiaries beginning August 1 until we notify them of the correct amount. And we will provide all hospitals with a Aplain language@ flyer to help explain the change to beneficiaries.

To assure as smooth an implementation as possible, we have undertaken an unprecedented provider

education campaign which has included:

- Allowing hospital representatives to attend our initial training session for intermediaries;
- Training sessions, town hall meetings and satellite broadcasts for providers to explain the new system and to answer questions;
- Use of the HCFA website to post the outpatient prospective payment system regulation, instructions, training materials and answers to questions received to date; and
- Weekly conference calls since April with provider associations to keep them apprised of the progress of implementation.

In addition, we are committed to implementing changes included in the BBRA to accommodate new technology in the outpatient prospective payment system. We are expanding the number of medical devices for which Apass-through@ payments will be made and continuing to work with the industry to determine additional devices for which these payments can be made. We also have committed to making unprecedented quarterly updates to the pass-through list to ensure that the outpatient prospective payment system does not inhibit development and use of new technologies.

In other steps to help hospitals, we have postponed expansion of the BBA=s Atransfer policy@ for all hospitals for a period of two years, through 2002. As a result, the transfer payment policy will apply only to the current 10 Diagnosis Related Group (DRG) categories, as prescribed by the BBA. We are carefully considering whether further postponement of this policy is warranted.

We have taken a number of specific administrative steps to assist rural hospitals. For example:

- We have made it easier for rural hospitals, whose payments are now based on lower, rural area average wages, to be reclassified and receive payments based on higher average wages in nearby urban areas.
- We are helping rural hospitals adjust to the new outpatient prospective payment system by using the same wage index for determining a facility=s outpatient rates that is used to calculate inpatient rates.
- We also are working with colleagues at the GAO and MedPAC to review the impact and appropriateness of the wage index that is used to factor local health care wages into Medicare payment rates and generally results in lower payments to rural hospitals than their urban counterparts.

We also are implementing BBRA provisions, including:

- Easing BBA DSH and IME reductions;
- Extending the Medicare Dependent Hospital program through 2005;
- Easing requirements for hospitals to qualify as Critical Access Hospitals;
- Allowing urban hospitals to reclassify to rural areas; and
- Allowing Sole Community Hospitals to have payments based on more recent hospital-specific costs.

HOME HEALTH

There has been a significant decline in home health spending since the BBA. This is due in large part to elimination of overpayments, waste, and fraud, but we are concerned about the potential for access

problems in some situations. GAO, MedPAC and the HHS Inspector General agree that there does not appear to be system-wide access problems. However, some studies have suggested that patients who have long-term conditions may have had increased difficulty in accessing home health services. The President's plan would:

- Replace the current law home health update of market basket minus 1.1 percentage points with a full market basket update for FY 2001; and
- Delay the BBA=s 15 percent reduction for an additional year until FY 2003.

Home health agencies will be greatly aided by the new home health prospective payment system that will take effect October 1. There has been a very positive response to our regulation detailing how this system will work, and the GAO has stated that it will Agenerally provide agencies a comfortable cushion to deliver necessary services.@ We also have taken steps to help home health agencies adjust to BBA changes, such as extending the time to repay overpayments and postponing the requirement for them to obtain surety bonds.

SKILLED NURSING FACILITIES

The BBA created a new prospective payment system for skilled nursing facilities (SNFs) that went into effect in 1998. This new system contributed to changes in the SNF market. Recent GAO and HHS Inspector General studies have found that SNFs were more cautious about admitting high-cost cases. An IG study found that 58 percent of hospital discharge planners reported that Medicare patients requiring extensive services such as intravenous medications have become more difficult to place in nursing homes. Additionally, several large private SNF chains have experienced financial problems that are primarily due to business practices unrelated to Medicare, but compounded by Medicare payment changes.

The President's plan would:

- Replace the BBA's SNF update of market basket minus 1 percentage point with a full market basket update for FY 2001.
- Delay for an additional year (until FY 2002) the application of the therapy caps providing additional time for development of policies.
- Drop the nursing home bad debt reduction budget proposal.

The BBA limited yearly payments for Part B physical/speech therapy and occupational therapy to $1,500 each per beneficiary. This limit meant that a large number of therapy patients had service use that exceeded the payment limits and thus paid for services out-of-pocket.

The BBRA put a two-year moratorium on the caps while a study is being conducted to determine appropriate payment methodologies that reflect the differing therapy needs of patients. However, the moratorium may not be long enough to complete this complicated work.

We are continuing to work to refine the payment classification system in a budget neutral way to ensure adequate payment for medically complex patients, and particularly to account more specifically for the cost of drugs and other Anon-therapy ancillary@ services. To immediately address some industry concerns, the BBRA provided for a 20 percent increase in the SNF prospective payments for 15 categories of patients to address perceived shortfalls in payments for such patients until we are able to determine the best way to make these changes. We implemented this BBRA provision in early June, and nursing homes

should be receiving the increased payments for services delivered on or after July 1.

Using the best data available in 1998, we developed two payment classification models we believed would ensure adequate payment for complex patients. We issued a proposed rule in April 2000 which included refinements based on these models and solicited public comments. In addition, we contracted with outside experts to validate the models using more recent data. When we tested the models with nationwide data from 1999 over the past few months, we found that the models were no longer statistically significant in identifying high-cost beneficiaries with complex care needs and the ancillary services they use.

Proceeding with implementation of the proposed refinements based on these models could have changed payment levels without any assurance that we were distributing funds more equitably, creating incentives for efficient care, and minimizing the risk of negative financial consequences. We therefore are deferring the implementation of the refinements.

We will shortly begin consulting with outside researchers and experts to begin further analysis using the 1999 national data aimed at determining the feasibility of developing case-mix refinements that reflect current practice. Our goal is to include a proposal for such refinements as soon as possible. However, until a feasibility study is completed, we will be unable to accurately forecast the potential and timing of such refinements.

In the meantime, the 20 percent increase in payments included in the BBRA will remain in place until refinements of the system can be implemented, which will be in fiscal 2002 at the earliest. In addition to the 20 percent increase, the BBRA also provided for a 4 percent increase in payments for all SNF beneficiaries, effective October 1, 2000.

END-STAGE RENAL DISEASE

Medicare covers about 300,000 people with end-stage renal disease (ESRD) B people who have diabetes, hypertension or other diseases that result in severe impairment of kidney function. Medicare=s composite rate (payment rate for outpatient dialysis services) has not kept pace with the increasing acuity of patients and cost of services. For the past several years, MedPAC has recommended updating the payment rate to reflect these factors.

The BBRA went part of the way to the MedPAC recommendation by updating it by 1.2 percent in 2000 and plans for another 1.2 percent increase in 2001 B the first increases since 1991. The President=s plan would meet the full MedPAC recommendation and increase rates by 1.2 percent for CY 2001 in addition to the BBRA increase of 1.2 percent.

OTHER ADJUSTMENTS

The President=s plan also drops proposed payment reductions for laboratories, ambulances, durable medical equipment, parenteral and enteral nutrients, and prosthetic and orthotics for fiscal years 2003 through 2007, as well as bad debt reductions for non-hospital providers, repeal of the BBRA managed care risk adjustment policy, and the proposal for a preferred provider option.

We also are continuing with development of additional prospective payment systems mandated by the BBA for inpatient rehabilitation facilities, and mandated by the BBRA for psychiatric hospitals, and long-term care hospitals.

As mentioned earlier, the President=s Mid-Session Review proposal includes $21 billion for unspecified policies. We look forward to working with Congress to develop additional policies to help providers adjust to the many BBA changes.

CONCLUSION

While it is essential that we maintain the fiscal discipline embodied in the BBA, it is equally important that we make adjustments where necessary to ensure beneficiaries= continued access to quality care. The improved status of the Medicare Trust Fund, combined with current budget surplus projections, provides the flexibility to make the prudent adjustments we are proposing, as well as to make a voluntary, affordable Medicare prescription drug benefit available to all beneficiaries. Enactment of such a benefit is urgently needed to meet beneficiary needs. It also is the best way to ensure that M+C plans can provide drug coverage and give beneficiaries the options Congress intended in the BBA. I thank you for holding this hearing, and I am happy to answer your questions.

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